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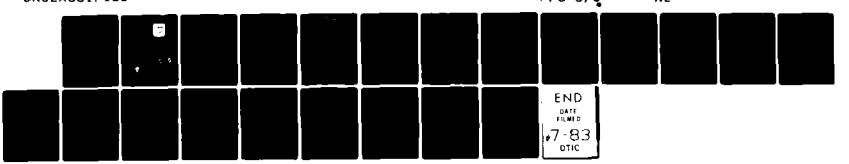

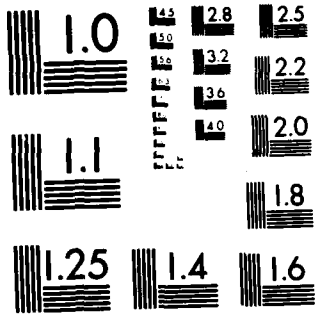

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STUDENT ESSAY

PUBLIC LAW 95-507

A PROPOSAL FOR A PROGRAM FOR RECRUITMENT OF RESERVE COMPONENT MEDICAL CORPS OFFICERS IN MEDICAL PLANNING FOR MOBILIZATION

BY

BRIGADIER GENERAL DOUGLAS D. BRADLEY

30 DECEMBER 1982

CORRESPONDING COURSE

US ARMY WAR COLLEGE, CARLISLE BARRACKS, PENNSYLVANIA

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Medical planning to provide physicians for mobilization is deficient in that there is an absolute shortage of physicians in the military, particulary in the most needed surgical and related specialties. A proposal has been made to provide for a new program of Reserve Component physician participation that allows for minimum but structured commitment of time, coupled with reasonable financial incentives, and the provision for increased participation in Reserve Component activities as an individual physician accrues more expendable time. It is felt that such a program would be a highly valuable and effective recruiting

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USAWC ESSAY

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by

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30 December 1982

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A PROPOSAL FOR A PROGRAM FOR RECRUITMENT OF RESERVE COMPONENT MEDICAL CORPS OFFICERS IN MEDICAL PLANNING FOR MOBILIZATION

INTRODUCTION

The prospect of mobilization for general war is a necessary but often a rather distant concept in the minds of planners, since the exact needs of mobilization are usually not clear until shortly before beginning of hostilities. At this point estimates will be available allowing for planning of a more specific nature for personnel and logistical requirements to support the military response. However, it has been said that the United States has never adequately and fully planned for a mobilization before it occurred.[1]

Mobilization planning remains an extremely complex task since, in any portion of the plan, a variety of levels of response must be considered, and practical methods of implementing these plans need be developed. In any war, but particularly with the concept of the high intensity battlefield, the medical support planning takes on special significance. The United States has perhaps been unique among countries in the development and evolution of the high level of medical support it has supplied its troops in the field.[2] There can be no doubt, however, of the practical benefits of this endeavor in maintaining a high level of morale in the fighting force and in helping maintain more physically able troops on the line. Finally, insofar as the maintenance of a creditable and competent military response contributes to deterrence, effective medical support planning becomes an important part of our overall military deterrent.[3]

This paper will focus on certain personnel procurement problems peculiar to the Medical Corps--particularly obtaining or identifying the necessary physicians in planning for and in support of mobilization. In future conflict, extraordinary requirements for surgical and trauma trained physicians are to be anticipated, and in earlier deployment than heretofore experienced. A proposal will be developed to create a special category of Reserve Component duty applicable to certain physicians to identify and make available individual physicians and skills appropriate to mobilization requirements.

The author has had approximately 20 years of military experience, equally divided between the Regular Army and the National Guard, all as a Medical officer. He has been assigned to Medical Centers, Meddacs, and to TOE medical units in various administrative capacities and currently is Commander of the 175th Medical Brigade, CALARNG. In subsequent sections of this paper he will further define the problem outlined here, discuss factors relevant to the motivation of physicians for military service, and then develop the proposal for a new category of physician Reserve Component duty relevant to fulfilling physician requirements for mobilization.

BACKGROUND DISCUSSION

The Active Component (AC) has done well in recent years in improving physician strength for peacetime requirements, falling only a few hundred physicians below approximately 5400 required. The Health Professional Scholarship Program (HPSP) has been very

effective and now provides about 50% of the physicians joining the Army during the past two to three years.[4] However, shortages exist in certain critical specialties including Orthopedic Surgery, Emergency Medicine, and Anesthesiology.[5,6] It is also in these critical specialties that mobilization planning falls short. The present mobilization contingency planning calls for filling of unit TOE physician requirements from Health Services Command (HSC) assets, including physicians currently assigned to Meddacs and Medical Centers. This would rapidly deplete the available resource of appropriately trained surgical specialists. A certain number of additional surgical specialists could be obtained from the USAR and NG but an overview of Reserve Component (RC) TOE Medical Units invariably shows a lack of assigned surgical specialists even where units report full strength in physician numbers. This represents a specialty skill identifier (SSI) "mismatch" which is a common factor in many RC Medical Units. During recent years, physicians of any specialty have been attracted and recruited to RC Medical Units in view of the severe shortage of physicians that these units have experienced. The result has been that even where significant numbers of physicians have been recruited, shortages of surgically trained physicians exist. And it is particularly in the surgical and related specialties, including Emergency trained physicians, that the greatest requirement exists to support a general mobilization.

The Active Army can support its peacetime requirements quite adequately through procurement of physicians from the HPSP program and from volunteers, although it remains difficult to attract physicians in certain surgical specialties. With mobilization,

an extreme and immediate drain of Active Component physicians would occur, and shortages of surgeons would exist. The Reserve Components could fill some of these shortages by mobilizing individuals and units of the USAR and NG, but absolute shortages of physicians, particularly those trained in surgery and trauma treatment also exist in these organizations.[7]

A separate factor not mentioned so far is that of anticipated time from mobilization to deployment of troops that may exist in future wars. All estimates suggest that these times will be much shorter than any past conflicts in which the US has been involved. The luxury of long periods of unit training prior to deployment will not likely exist in future wars, either with combat or support units.

An effective but prohibitively expensive solution to this problem is to have a large highly professional standing Army, including the various support units including the Medical Service. A more practical alternative would be the development of more effective Reserve Component Medical Units providing the proper fill of professional personnel. In addition, the entire professional complement of an RC unit would perhaps not need to be assigned in peacetime, but only identified as available by SSI. Several methods of procuring physicians for Reserve Component Unit activities are in practice or in formulation. These include the direct recruitment of physicians for RC duty, the PRIMUS program (Physician Reservists in Medical Universities and Schools)[8] and Medical TDA Health Professional Detachments.[9, 10]

In addition, flexible forms of physician management have been utilized in many RC medical units to help in maximizing physician

participancy and retention. Some of the recent programs designed for physicians show some promise in attracting needed specialists, but so far gains in physician strength in RC units have been modest. The reasons for this are apparently complex, but large time demands on physicians in surgical specialties and economic factors (higher civilian income levels) are likely contributing factors to lower levels of participation in RC unit duty.

The progress shown still does not address the pressing question of the shortage of the very large numbers of surgical specialists and specialists in related fields needed for mobilization. In the PRIMUS fact sheet[11] Department of Defense estimates a wartime shortage of 12,000 physicians (all services) and dictates policy that mobilization requirements above peacetime needs will come primarily from the Reserve Components and secondarily from other governmental sources and, as possible, from the civilian community.

Clearly, improvement in recruiting and retaining physicians in the Reserve Components is needed to identify and make available physicians in critical medical specialties for Reserve Component Duty to enhance mobilization preparedness.

DEFINING THE PROBLEM

Simply stated there are not enough physicians trained in the surgical specialties and trauma treatment for assignment during the early period of a general mobilization. The Active Component (AC) will provide the early deployable physician fill of TOE Medical Units but absolute shortages can be expected to exist. The USAR and National Guard are a valuable resource in providing individual

physicians and units to fill the mobilization requirements. However, the likely demands of modern war in the high intensity battle and with very short mobilization to deployment time place demands for numbers of surgically trained physician specialists that are not identified at the present time.

The paradox exists that, due to medical school expansion in the past, an overall physician excess in the 1980's is imminent. However, the association and familiarization of a certain number of these physicians with the military establishment is necessary in order to provide the required early mobilization requirements.

As mentioned earlier, the active component has been increasingly successful in filling its peacetime requirements for physicians, which appears due to a combination of factors, including increased salary competition with comparable civilian jobs and the current increasing pool of available physicians in the 1980's. The Reserve Components remain short of physicians although new incentive programs such as PRIMUS and the medical detachment concept show promise in adding certain numbers to the RC ranks. The problem remains, however, to recruit and attract physicians in large enough numbers in appropriate surgical specialties to support mobilization.

FACTORS IN MOTIVATION OF PHYSICIANS FOR RESERVE COMPONENT DUTY[12, 13, 14]

In observing and working with physicians in various military and civilian environments over twenty-five years, I would judge that the motivations and values of physicians are probably little different than any other large group of professionals.

Physicians generally are compulsive and time oriented--qualities which help them through the rigors of their medical education. As a group, they are highly motivated towards self-improvement through continuing education, as this has been structured into their educational process beginning in medical school. Activities which are diversionary from the stresses of a busy medical practice can be attractive, but absolute time availability remains a problem. Available time varies significantly with involvement in medical training, family responsibilities, type of practice and level of involvement in other non-medical activities. With reference to type of practice, physicians in an individual practice or small group usually have less flexibility in available time than a physician in a large group or institutional practice. Physicians in training programs have such severe requirements on this time that outside activities often are severely curtailed or impossible. When the demands and requirements of a family are superimposed on a physician's professional life, the problems of time are strained even more.

Financial rewards are not as important to physicians as are job satisfaction, feeling of accomplishment and individual importance and recognition (promotion). However, physicians in different career phases will view these matters in varying perspective. Younger physicians in training or just out of training are frequently interested in financial compensation due to an accrued educational debt, increasing family and personal expenditures, and other factors. Older physicians, generally at higher income levels, are less interested in pay, may have more time flexibility, and

are interested in diversion from practice stresses. However, they also place a high priority on time, as it often is their most precious commodity.

With specific respect to military service, either Active or Reserve Component duty, I would say that the physician population parallels the general population with respect to the concepts of duty to country and patriotism. These factors will change with the political climate, world tensions and with the threat to the country and to the perceived threat to the individual. In peacetime, motivations to serve in the military are less intense than in war, but with a general mobilization we unquestionably would have a high level of dedication and cooperation from the medical community.

In summary, motivations of physicians vary as might be expected, with the stage of life and career of the individual. Financial compensation has some importance, particularly to younger physicians. Time constraints are typical with all physicians, although physicians with the flexibility of large group practices or institutional practice may have greater time flexibility. Self-improvement through access to continuing health education is naturally attractive to physicians, and opportunities for recognition, accomplishment, and diversion from the routine interest physicians as they would any group of professionals. The application of these characteristics in the physician procurement process for the military Reserve Components will be addressed next.

PROPOSAL FOR A SPECIAL PROGRAM FOR RECRUITMENT OF MEDICAL CORPS OFFICERS IN THE RESERVE COMPONENT

There have been a number of incentives for participation in RC military programs by physicians,[15, 16, 17, 18, 19] and many others have been proposed over the years and not implemented. The availability of CHE (Continuing Health Education) has been used with some effectiveness, and a "flexible approach" towards the use of physician time has been adopted by most RC units. However, this has not increased the availability of surgically trained physicians nor dramatically increased physician strength overall. It has probably increased motivation for retention of some of the physicians who have chosen to participate in RC activities at the present time.

A survey of RC physicians' opinions in 1980 suggested that there was above-average interest in a "proposed new (reduced) level" of participation in RC activities in which retirement points would be accrued and no regular IDT or AT was required except for an initial two week "orientation."[20] No promotion potential past O-4 existed in this proposal. Based on this type of demonstrated interest and discussions with other interested Medical Corps officers,[21, 22, 23] plus personal observations, I have developed a framework for another proposal that I believe addresses all of the major problems outlined, would be practical and cost effective, and would be favorably received by the numbers of physicians needed to provide the minimum physician support for mobilization.

The basis for the proposed plan follows in outline form:

1. Provide increased availability of physicians in RC pool for mobilization biased toward surgically and trauma trained physicians. Fill surgically related TOE vacancies first.

2. Restrict time requirements to two IDT periods (4 UTA each) at 6 month intervals each year. Be available for call-up for declared war. IDT paid by usual military pay scale.

3. Active duty requirements--none specifically required. Optional AT paid by usual military pay scales.

4. Retirement points--Allow credit of 25 points in recognition of level of training achieved through civilian schooling. (Two years to accrue 50 points equivalence of one good year for retirement.)

5. Bonus--$250 to $375 paid quarterly or $500 to $750 paid semi-annually for recognition of level of training and potential value to the military.

6. Potential for promotion--Promotion to O-4 possible, using established criteria, during reduced participation. Promotability after conversion to standard Reserve program would revert to that allowed by regulation based on level of military education and time in grade.[24]

7. Duration of program--For non-prior service physicians, a statutory 6-year commitment as with other RC programs, extendable to a maximum of 10 years. (Consider a year-to-year commitment as a viable alternative, up to a maximum of 10 years. This would require special legislation.) Prior service physicians could participate with no specific obligated period of service. After 10 years, service can be continued by conversion to standard Selected Reserve programs of USAR or NG; the IRR, ING or as individual mobilization augmentee (IMA). A waiver may be allowed to continue in reduced participation status for individuals with specified critical skills.

The outlined proposal would be a new and valuable tool in recruiting physicians to provide orderly support for mobilization. In addition, it provides certain incentives and provisions of value to both the military and the individual. The program would place

minimum time constraints on the individual while offering reasonable financial remuneration for the time required for orientation to the military mission and to unit function. A periodic IDT exposure at 6-month intervals was structured into the proposal in order to develop a continuing association and familiarity with the unit to which the individual is assigned. The proposal allows for additional voluntary participation by a physician as his motivations and/or time constraints change. The proposed benefits have been kept below those provided by the minimum selected reserve participation so that motivation is structured into the program to advance to a higher level of participation when the individual feels he has time to do so. Similarly, promotability past O-4 is limited to participants in the regular selected reserve programs.

The medical mobilization preparedness would be substantially improved by the provision of increased numbers of surgical and trauma specialists for mobilization since the program is biased to fill these TOE vacancies first. The Reserve Component units receiving these physicians could generally function well without the regular participation of all physicians occupying TOE lines. A maximum percentage of total physician strength provided by minimum participation should be established at 50%, so that one-half of the physician strength would be available for month-to-month unit requirements in peacetime. The program would be readily adaptable to both the USAR and the NG and would provide critical SSI physicians to both TOE and TDA units. However, the assignment of physicians with limited military orientation would best be limited to General, Field, Evacuation, and Combat Support Hospitals and restricted from assignment to Divisional Medical Units or MASH hospitals early in mobilization.

The cost effectiveness of any new proposal must be addressed, but it is my belief that the proposed program would be very effective from the standpoint of value received. The individuals would in general be paid for time served as with any other Reserve Component activity. The bonus of $1000 - $1500 annually plus other paid benefits equates to approximately $1.5 - $2 million per year to identify the individuals and establish a minimum mobilization obligation for 1000 physicians in the most needed medical specialties.

In today's economics I believe that this would be a genuine bargain in attracting physicians to the Reserve Component and would significiantly improve medical preparedness for mobilization.

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FOOTNOTES

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9. Oscar L. Carroll, COL, MSC USAR, Professional Detachments (Proposal), DASG-PTZ-R, Tb. F.

10. Thomas Gore, COL, MSC, Medical TDA "Health Professional Detachments," pp. 1-3.

11. Fact Sheet on Physician Reservists (PRIMUS).

12. Interview with Frank Ledford, BG.

13. Interview with Gary Truex, COL, MC, Commander 146th Combat Support Hospital, CALARNG, San Francisco, 18 December 1982.

14. Interview with James Q. Simmons III, MG, MC, Deputy Assistant to the Surgeon General, USA, for Reserve Affairs, Los Angeles, 2 October 1982.

15. John F. Beary, III, MD, Memorandum: Providing More Flexible Training Opportunities for Reserve Component Physicians.

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21. Interview with Frank Ledford, BG.

22. Interview with Gary Truex, COL.

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24. US Department of the Army, Army Regulations 135-101, Para. 3-2, pp. 3-1 through 3-4.

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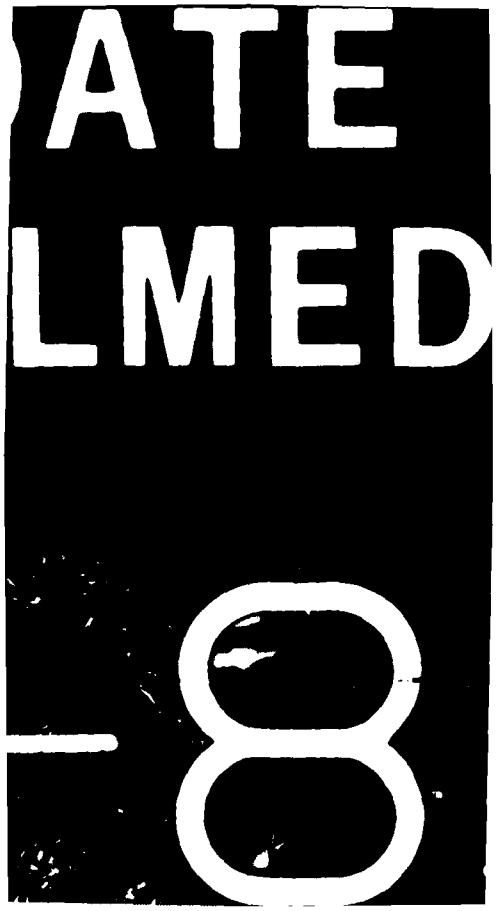
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